

Aboriginal Health and Medical Research Council of NSW

Inquiry into racism, hate and violence
directed at Aboriginal and Torres
Strait Islander people.

Date: 01.06.2026

The AH&MRC Acknowledges the Traditional Owners of the lands on which the AH&MRC stands, the lands of the Bidjigal and Gadigal people of the Eora Nation. The AH&MRC pays respect to Elders past, present and emeraina.



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About the AH&MRC

The AH&MRC, formerly the Aboriginal Health Resource Co-op (AHRC) was established in 1985 following a recommendation of the Brereton Report by the NSW Aboriginal Task Force on Aboriginal Health in 1982-83.

The AH&MRC assists the ACCHO Sector across NSW to ensure they have access to an adequately resourced and skilled workforce to provide high-quality health care services for Aboriginal communities.

As the Peak Body for Aboriginal Health in NSW the AH&MRC represents the rights and interests of 52 Member Services. The AH&MRC is committed to the delivery of four key priorities. These are:

- Aboriginal Community Control and Innovation
- Education and Workforce
- Research and Data
- Governance and Finance

The AH&MRC works collaboratively with the ACCHO Sector across NSW to ensure accessibility, sustainability and adequate resourcing of a skilled workforce providing comprehensive primary health care services for Aboriginal communities.

Opportunity to review

Thank you for this opportunity to make a submission to the Joint Standing Committee on Aboriginal and Torres Strait Islander Affairs, regarding the inquiry into racism, hate and violence directed at Aboriginal and Torres Strait Islander people.

We understand that the catalyst for this select committee to investigate racism has been the sharp rise of extremist racism, targeting both Aboriginal people and other racialized groups.

As the peak body for Aboriginal Community Controlled Health Organisations (ACCHOs) in New South Wales, we value this opportunity to reflect on the impact of racism on health outcomes for Aboriginal people and the necessary action that must be taken to address racism and close the gap. For this submission, we have been guided by the contributions of our staff, members services, and community, with particular thanks to Maari Ma Health Aboriginal Corporation for the time and knowledge they have contributed to this submission.

In line with the inquiry terms of reference and the remit of the AH&MRC, the focus of this submission will be on the health impacts of racism both inside of and outside of the healthcare sector, and the need for anti-racist action and the establishment of a cultural safety standard within public institutions to resolve it.

For this submission, we will be respectfully referring to all Aboriginal and Torres Strait Islander people as Aboriginal people.

Background

Aboriginal people have been living in collaboration with this land for over 65,000 years¹. There are more than 250 Indigenous languages, and around 800 dialects², each with complex traditions,

¹ *Historical Context - Ancient History | Bringing Them Home*. (2016). Humanrights.gov.au.

<https://humanrights.gov.au/bringing-them-home/significance/historical-context-ancient-history.html>

² Australian Institute of Aboriginal and Torres Strait Islander Studies. (2023). *Languages alive*. AIATSIS.

<https://aiatsis.gov.au/explore/languages-alive>

stories, politics, and cultures³. Aboriginal sovereignty is continuous and undisrupted, even as it goes unrecognised.

The contemporary experience and impact of racism on Aboriginal people cannot be divorced from the context of settler colonialism and the intentional and systematic genocide of Aboriginal people. From invasion, the settler-colonial project has been conveniently alibied by the prevalence of racism⁴; invasion itself was ideologically possible because of the precedent set by terra nullius⁵, and it is harmful to strip this convenience of its racist intent. By defining Aboriginal Nations out of the western understanding of governance and ownership, it allowed for moral certainty that invasion would not only be economically fruitful, but beneficial to the inferior and problematic native population. Racism, narrativized and systemic, must be acknowledged as not just harmful to the subject, but beneficial to the racist. Racism toward Aboriginal people is ideologically helpful to the colony and its continued stake in the occupation of Aboriginal land. In order to properly address racism, we must consider and acknowledge how our systems incentivise racist decisions, and how those racist decisions reinforce the systems that support it.

Racism can be defined as organized systems within societies that cause avoidable and unfair inequalities in power, resources, capacities and opportunities across racial or ethnic groups. Racism can manifest through beliefs, stereotypes, prejudices or discrimination. This encompasses everything from open threats and insults to phenomena deeply embedded in social systems and structures⁶.

That embedded racism is particularly apparent in the health space. The Aboriginal conception of health is varied and diverse across Australia but differs keenly from western medical perspectives that often reflect the poorer health outcomes for Aboriginal people as personal deficits⁷. Colonial medical perspectives are concerned with ‘organic malfunction’, disease and illness, and the translation of the life world ‘into a medicine that directs clinical attention to all domains of human life⁸.’ These models draw all aspects of human experience into the domain of medicine, so that it can be recontextualised using the language of pathology and wellness. As opposed, the Aboriginal understanding of health and healing instead draws the medicine out into the domains of life, community and experience. As per the NACCHO constitution:

“Aboriginal health” means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life⁹.

³ Pascoe, B. (2014). *Dark emu, black seeds: Agriculture or accident?* Magabala.

⁴ Paradies, Y. (2016). Colonisation, Racism and Indigenous Health. *Journal of Population Research*, 33(2), 197–197. <https://doi.org/10.1007/s12546-016-9162-3>

⁵ National Library of Australia. (2024, October 17). *Challenging terra nullius*. Library.gov.au. <https://www.library.gov.au/learn/digital-classroom/legend-and-legacy-james-cook/challenging-terra-nullius>

⁶ Mohamed, J., Stacey, K., Chamberlain, C., & Priest, N. (2024). *Cultural Safety in Australia* (p. 14). Lowitja Institute.

⁷ Chittleborough, E., Delbridge, R., Coveney, J., Wilson, R., Mackean, T., & Wilson, A. (2023). Challenging deficit discourse in Aboriginal and Torres Strait Islander nutrition and dietetics research: A critical discourse analysis. *SSM - Qualitative Research in Health*, 4, 100323. <https://doi.org/10.1016/j.ssmqr.2023.100323>

⁸ Farre, A., & Rapley, T. (2017). The new old (and old new) medical model: Four decades navigating the biomedical and psychosocial understandings of health and illness. *Healthcare*, 5(4), 88. <https://doi.org/10.3390/healthcare5040088>

⁹ Demant, D., Manton, D., Manton, J., Saliba, B., & Avery, S. (2025). *Health Inequities in Australia: A Scoping Review on the Impact of Racism on Indigenous and Other Negatively Racialised Communities’ Health Outcomes and Healthcare Access*. Australian Human Rights Commission.

Farre, A., & Rapley, T. (2017). The new old (and old new) medical model: Four decades navigating the biomedical and psychosocial understandings of health and illness. *Healthcare*, 5(4), 88. <https://doi.org/10.3390/healthcare5040088>

Summary

For Aboriginal people, the experience of racism is not just a series of incidents, but a thematic context of life. Racism exists across all domains; it cannot be separated out into instances of interpersonal, systemic or internalised racism, but must be considered as a cohesive structure, each supporting the other and experienced as a psychological, economic, structural, and overwhelming onslaught.

In 2017, the Uluru Statement of the Heart wrote:

Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are alienated from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future.

These realities faced by Aboriginal communities must be recognised as they are: racist.

This submission will explore the effects of racist ideologies, policies, and behaviour on health outcomes for Aboriginal people and the potential approaches to address the entrenched and systematised racism that exists in our society through three key ideas:

- Racism is prevalent *within* our healthcare systems and is detrimental to the health of Aboriginal communities.
- Racism is prevalent *outside* of our healthcare systems and is detrimental to the health of Aboriginal communities.
- Racism can't be 'combated' in isolation from structural injustice. Cultural safety can only be determined by Aboriginal people

Aboriginal people deserve the same standard of healthcare as everyone else, deserve the same quality of life, deserve to have the racism they experience identified as such, and addressed as though it's important.

AH&MRC response

Racism is prevalent within our healthcare systems and detrimental to the health of Aboriginal communities.

The healthcare sector has long been intertwined with racism and continues to be implicated in the removal of Aboriginal babies from their families¹⁰, the abuse and neglect of Aboriginal consumers¹¹, the perpetuation of historical trauma¹², and the disempowerment of Aboriginal people. In a recent study on the effects of racism on mental health, 97 percent of Aboriginal survey respondents indicated they had experienced at least one racist incident within the last 12-months, with one-third of those experiencing racism in a healthcare setting¹³. It is important to frame this racism not as a series of personal slights or poor behaviour, but as a fundamental threat to wellbeing. The prevalence of racism in healthcare will impact not only one person's feelings, but the quality of care they receive, their choice to access it, the perspectives of their community, and

¹⁰ Jones, M., Leane, C., Ah Kit, J., & Hood, N. (2026). Removal of Aboriginal infants in a hospital setting: Examining practices. *Child Abuse & Neglect*, 175, 107752. <https://doi.org/10.1016/j.chiabu.2025.107752>

¹¹ Australian Institute of Health and Welfare. (2023). *Cultural safety in health care for indigenous australians: Monitoring framework, module 2: Patient experience of health care*. Australian Institute of Health and Welfare. <https://www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework/contents/module-2-patient-experience-of-health-care>

¹² Paradies, Y. (2016). Colonisation, Racism and Indigenous Health. *Journal of Population Research*, 33(2), 197–197. <https://doi.org/10.1007/s12546-016-9162-3>

¹³ Kelaher, M. A., Ferdinand, A. S., & Paradies, Y. (2014). Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities. *The Medical Journal of Australia*, 201(1), 44–47. <https://doi.org/10.5694/mja13.10503>

their quality of life. Racism is not experienced as a series of isolated events, but as an unrelenting, internal understanding¹⁴ that health systems are not safe and care is not guaranteed.

Aboriginal people's trust in the healthcare system is often cited as a barrier to service accessibility¹⁵, and this is often represented as something that needs to be managed by the system itself. Health systems must give the appearance of trustworthiness through posters, artworks, and Aboriginal-designed scrubs. But the window-dressing does nothing to address the very real and serious implications of racism within the health sector. Aboriginal people's trust in the healthcare system is not a self-imposed barrier to care, but a reasonable recognition of unsafety.

That unsafety can be exemplified in an unending slew of case studies, patient stories, oral histories, and community narratives, but it is particularly apparent in the treatment of Aboriginal people in end-stage kidney disease. Aboriginal consumers experience longer wait times before receiving a donor kidney than their non-Aboriginal counterparts, if they do at all, and they are more likely to be confined to facility-based haemodialysis rather than home-based therapies¹⁶. Long-term haemodialysis is associated with a myriad of complications, including infection, anaemia, undernutrition¹⁷, and an increase in psychological distress that gets worse over time¹⁸, all of which Aboriginal consumers are disproportionately affected by. In a study seeking to understand the decision made by medical providers to recommend Aboriginal patients for transplantation, non-compliance was considered a significant contributor¹⁹, with one nephrologist stating: "If you (the patient) can't comply with dialysis, how do you expect me to trust you to comply with transplantation?" This was despite the fact that 'non-compliance' couldn't be adequately described or demonstrated as a good predictor of compliance after transplantation.

Aboriginal people are constantly deemed to be 'high risk', 'complex', and 'non-compliant' with little introspection paid to the subjective and potentially biased assessments that alibi racist medical decision making²⁰. Despite adherence to medication being one of the few qualities of non-compliance that can be adequately described, it has been found that 'there is no evidence that medication adherence amongst Indigenous Australians is lower than for the general population'²¹. On top of that, if Aboriginal people do struggle with adherence to medication or strict dialysis regimes in culturally unsafe mainstream services, with limited transport options and historical dispossession, that is an issue of the provider, not the patient. 'Non-compliance' should be

¹⁴ Bastos, J. L., Harnois, C. E., & Paradies, Y. C. (2018). Health care barriers, racism, and intersectionality in Australia. *Social Science & Medicine*, 199(199), 209–218. <https://doi.org/10.1016/j.socscimed.2017.05.010>

¹⁵ Nolan-Isles, D., Macniven, R., Hunter, K., Gwynn, J., Lincoln, M., Moir, R., Dimitropoulos, Y., Taylor, D., Agius, T., Finlayson, H., Martin, R., Ward, K., Tobin, S., & Gwynne, K. (2021). Enablers and barriers to accessing healthcare services for aboriginal people in new south wales, australia. *International Journal of Environmental Research and Public Health*, 18(6), 1–13. <https://doi.org/10.3390/ijerph18063014>

¹⁶ Hughes, J. T., Cundale, K., Owen, K. J., & McDonald, S. P. (2023). Advancing accessible kidney transplantation for Aboriginal and Torres Strait Islander people: the National Indigenous Kidney Transplantation Taskforce. *Medical Journal of Australia*, 219(S8). <https://doi.org/10.5694/mja2.52112>

¹⁷ Habas, E., Habas, A., Elgamal, M., Shraim, B. A., Ibrahim, A., Danjuma, M., Moursi, M. O., & Elzouki, A.-N. Y. (2021). Common complications of hemodialysis: A clinical review. *Ibnosina Journal of Medicine and Biomedical Sciences*, 13(04), 161–172. https://doi.org/10.4103/ijmbs.ijmbs_62_21

¹⁸ Bakhsh, A. M., & Mahallawi, W. H. (2025). Psychological Effects of Hemodialysis on Patients with Renal Failure: A Cross-Sectional Study. *Journal of Clinical Medicine*, 14(20), 7136. <https://doi.org/10.3390/jcm14207136>

¹⁹ Anderson, K., Devitt, J., Cunningham, J., Preece, C., Jardine, M., & Cass, A. (2012). If you can't comply with dialysis, how do you expect me to trust you with transplantation? Australian nephrologists' views on indigenous Australians' "non-compliance" and their suitability for kidney transplantation. *International Journal for Equity in Health*, 11(1), 21. <https://doi.org/10.1186/1475-9276-11-21>

²⁰ Wain, T., Sim, M., Bessarab, D., Mak, D., Hayward, C., & Rudd, C. (2016). Engaging Australian Aboriginal narratives to challenge attitudes and create empathy in health care: a methodological perspective. *BMC Medical Education*, 16(1). <https://doi.org/10.1186/s12909-016-0677-2>

²¹ de Dassel, J. L., Ralph, A. P., & Cass, A. (2017). A systematic review of adherence in Indigenous Australians: an opportunity to improve chronic condition management. *BMC Health Services Research*, 17(1). <https://doi.org/10.1186/s12913-017-2794-y>

considered an indicator that the health system has failed and has a responsibility to do better, but instead of engaging with structural accountability and reform, Aboriginal consumers end up bearing the burden of racist failures.

Racist decision-making can be seen across the healthcare sector, in all specialties and all mainstream settings. The rate of involuntary mental health treatment for Aboriginal people is over five times that of non-Indigenous people²². Aboriginal consumers receive less analgesic pain management in post-operative care²³ and in musculoskeletal pain treatment²⁴. Clinicians make assumptions about opioid dependency and ‘*drug-seeking*’ behaviour when caring for racialized patients²⁵. Aboriginal consumers are constantly subjected to the discretionary decision-making of medical professionals, with extremely limited capacity to rebuke the system. Aboriginal consumers don’t have the cultural safety within our healthcare system to question professional choices about kidney transplant options, to resist involuntary admission, to advocate for greater pain management without the risk of being further stigmatized, deemed ‘*agitated*,’ ‘*aggressive*,’ ‘*non-compliant*.’ Aboriginal consumers are forced into managing the prejudices of healthcare providers, and even then, will still be subjected to practitioner bias, racism, and receive a lower standard of care that can and regularly does cause the loss of life²⁶ and grievous injury²⁷. Aboriginal people cannot even leave healthcare settings without being the subject of paternalistic and racist rebuke:

‘People who self-discharge are generally perceived as poor decision makers and castigated, either to their face or in their medical records, for behaving inappropriately. The very language used is adversarial and denotes a hierarchy where health professionals’ decisions and opinions take precedence over those of their patients, rendering patients relatively powerless. If a patient does decide to self-discharge, their reasoning is questioned, and they are typically derided as irrational and labelled as demanding’²⁸.

Solutions to the treatment of Aboriginal people in hospital face significant racist backlash, such as a St Vincents Hospital in Melbourne’s new strategy to see Aboriginal patients faster after triage, or short-term and unsustainable funding models that instil a sense of distrust in consumers. Aboriginal people understand the role of hospitals in health provision. They care deeply about their health and the health of their communities, but to access life-saving care they are forced to accept a higher degree of risk than non-Aboriginal consumers. They risk being subjected to ignorant and prejudiced stereotypes that could impact their access to treatment; they risk being pathologized, abused or mistreated; they risk their agency. They risk being misunderstood by a

²² AIHW. (2026). *Involuntary treatment in public mental health care*. Australian Institute of Health and Welfare; Australian Government. <https://www.aihw.gov.au/mental-health/topic-areas/safety-quality/involuntary-treatment>

²³ Arthur, L., & Rolan, P. (2019). A systematic review of western medicine’s understanding of pain experience, expression, assessment, and management for Australian Aboriginal and Torres Strait Islander Peoples. *PAIN Reports*, 4(6), e764. <https://doi.org/10.1097/pr9.0000000000000764>

²⁴ Lin, I. B., Bunzli, S., Mak, D. B., Green, C., Goucke, R., Coffin, J., & O’Sullivan, P. B. (2018). Unmet Needs of Aboriginal Australians With Musculoskeletal Pain: A Mixed-Method Systematic Review. *Arthritis Care & Research*, 70(9), 1335–1347. <https://doi.org/10.1002/acr.23493>

²⁵ Plaisime, M. V., Jipguep-Akhtar, M.-C., & Belcher, H. M. E. (2023). “White People are the default”: A qualitative analysis of medical trainees’ perceptions of cultural competency, medical culture, and racial bias. *SSM - Qualitative Research in Health*, 4(1), 100312. <https://doi.org/10.1016/j.ssmqr.2023.100312>

²⁶ Grahame, H. (2019). *Inquest into the death of Naomi Williams*. STATE CORONER’S COURT OF NEW SOUTH WALES.

²⁷ Jayakody, A., Oldmeadow, C., Carey, M., Bryant, J., Evans, T., Ella, S., Attia, J., & Sanson-Fisher, R. (2018). Unplanned readmission or death after discharge for Aboriginal and non-Aboriginal people with chronic disease in NSW Australia: a retrospective cohort study. *BMC Health Services Research*, 18(1). <https://doi.org/10.1186/s12913-018-3723-4>

²⁸ Askew, D. A., Foley, W., Kirk, C., & Williamson, D. (2021). “I’m outta here!”: A qualitative investigation into why Aboriginal and non-Aboriginal people self-discharge from hospital. *BMC Health Services Research*, 21(1), 1–10. <https://doi.org/10.1186/s12913-021-06880-9>

system that refuses to grapple with its own place within the colonial project. Racism exists in the foundational structures of our public health system, from government run outreach clinics to public hospitals to mainstream primary health services. It is understandable then, that Aboriginal communities would experience less trust in physicians and the broader health system; it is not sensitive or frivolous to recognise the health system as a potential danger, it's reasonable. In order for Aboriginal people to trust the health system, to take those risks, the health system has a responsibility to be trustworthy.

Racism is prevalent outside of our healthcare systems and detrimental to the health of Aboriginal communities.

Alongside health provision, racism is felt in every other facet of life as well, from housing to the justice system, employment and child protection, to simply navigating a fraught political reality. Instances of racism towards Aboriginal people have significantly increased in the last decade²⁹, exacerbated by the failed Indigenous Voice to Parliament Referendum³⁰ and the emerging influence of far-right racist politics³¹. In the Reconciliation Australia Barometer snapshot report, 56 percent of Aboriginal respondents stated belief that Australia is a racist country, and that response is not without reason. 35 percent had been verbally abused, 25 percent of Aboriginal respondents reported being prevented from renting or buying a property, 23 percent had been physically assaulted³². Of the seventeen Closing the Gap targets tracked by the Productivity Commission, only three are on track³³. Aboriginal children are still 9.8 times more likely to be removed from the care of their families³⁴, one in three incarcerated people are Aboriginal³⁵. Aboriginal people are still expected to live eight fewer years than non-Aboriginal people³⁶ and face a disproportionate chronic disease burden³⁷. There is nothing innate about Aboriginal people that should result in these statistics. They are not representative of Aboriginal people, but of racism.

As recently as ANZAC day 2026, Aboriginal Elders were booed during the Welcome to Country across the country at dawn services from Sydney to Perth³⁸, encouraged by far-right extremist groups on social media. One stated: *'how loud will you be?'* superimposed over a video of Bunurong elder Uncle Mark Brown being booed by members of the National Socialist Network at

²⁹ Reconciliation Australia. (2024). *Reconciliation Snapshot: Racism and First Nations Peoples*. Reconciliation Australia.

³⁰ Allison, F., Cunneen, C., & Coombes, L. (2025). *"If you don't think racism exists come take a walk with us" Call it Out Racism Register 2023–2024*. Jumbunna Institute for Indigenous Education and Research, University of Technology Sydney.

³¹ Grant, C. (2022). *Briefing Book, 47th Parliament: Right-wing extremism in Australia*. Parliament of Australia.

³² Reconciliation Australia. (2024). *Reconciliation Snapshot: Racism and First Nations Peoples*. Reconciliation Australia.

³³ Productivity Commission. (2025). *Dashboard - Closing the Gap*. Pc.gov.au. <https://www.pc.gov.au/closing-the-gap-data/dashboard/#new>

³⁴ SNAICC: National Voice for our Children. (2025). *Family Matters: Report 2025* (p. 17).

³⁵ Australian Bureau of Statistics. (2024, December 19). *Prisoners in Australia*. Australian Bureau of Statistics. <https://www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia/latest-release>

³⁶ *Life expectancy*. (2020). AIHW Indigenous HPF. <https://www.indigenoushpf.gov.au/reports/summary-reports/summary-report/4-tier-1-%E2%80%93-health-status-and-outcomes/life-expectancy>

³⁷ *Leading causes of disease burden and mortality*. (2018). AIHW Indigenous HPF. <https://www.indigenoushpf.gov.au/reports/summary-reports/summary-report/4-tier-1-%E2%80%93-health-status-and-outcomes/leading-causes-of-disease-burden-and-mortality>

³⁸ *Booing at Melbourne, Sydney and Perth Anzac Day services draws widespread condemnation*. (2026, April 25). Abc.net.au. <https://www.abc.net.au/news/2026-04-25/anzac-day-booing-heckling-melbourne-sydney-condemnation/106605674>

a dawn service in 2025³⁹. These racist incidents are not isolated events but are representative of an ongoing and coordinated effort to delegitimise Aboriginal customs and progress a white nationalist agenda. Across two consecutive ANZAC days, Australians have booed during the Welcome to Country, and for two consecutive years the opposition leader has first condemned the booing, before following it up by saying that Welcomes to Country are either ‘overdone’ or ‘overused.’ This use of verbiage is either an embarrassing demonstration of inadequate knowledge or a fundamental disrespect to Aboriginal customs. A Welcome to Country performed by an elder of that country is not culturally optional, to suggest that it can be ‘overused’ is to represent Aboriginal culture as expendable and finite; for the benefit of the non-Aboriginal audience.

For all the discussion of *social cohesion* in recent months, there has been a marked lack of action on the functional impacts of racism directed at Aboriginal people, including by those implicated by political office. Aboriginal communities are disproportionately affected by environmental injustice and public policy which impacts access to clean air, clean soil, clean water, and safe housing⁴⁰. Lead exposure in Aboriginal children is a particularly striking example. Lead is a naturally occurring heavy metal that acts as a cell-damaging toxin in the human body⁴¹, causing irreparable damage to the soft tissues like the liver, kidneys, lungs, cardiovascular system and brain, as well as accumulating in the bones⁴². Exposure to high levels of lead can result in devastating injury, including coma, seizures, and death, but even lower levels can dramatically affect the lives of children exposed:

In particular, (lower levels of) lead can permanently affect children’s brain development, resulting in reduced intelligence quotient (IQ), behavioural changes including reduced attention span and increased antisocial behaviour, and reduced educational attainment. Lead exposure also causes anaemia, hypertension, renal impairment, immunotoxicity and toxicity to the reproductive organs⁴³.

In Broken Hill, 68% of Aboriginal children have blood lead levels (BLLs) above the threshold of five micrograms per decilitre, even after 30 years of attempted lead remediation⁴⁴. Aboriginal children are almost twice as likely as non-Aboriginal children to have BLLs above the threshold and six times as likely to have BLLs greater than even twenty micrograms per decilitre. This kind of long-term lead exposure will be passed down to these children’s children in pregnancy⁴⁵ and shorten the length of their lives⁴⁶. It will contribute to the development of chronic diseases, like chronic kidney disease which is exacerbated and accelerated by long-term lead exposure in

³⁹ Butler, J. (2026, April 27). *Anti-immigration group claims it did not organise Anzac Day booing despite post asking “how loud will you be.”* The Guardian; The Guardian. <https://www.theguardian.com/australia-news/2026/apr/27/anzac-day-indigenous-leaders-welcome-country-booed-anti-immigration-group-ntwnfb>

⁴⁰ Mathew, S., Pereira, G., Zander, K. K., Thakur, R., & Payi, L. (2023). Environmental health injustice and culturally appropriate opportunities in remote Australia. *The Journal of Climate Change and Health*, 14, 100281–100281. <https://doi.org/10.1016/j.joclim.2023.100281>

⁴¹ Wani, A. L., Ara, A., & Usmani, J. A. (2015). Lead toxicity: a review. *Interdisciplinary Toxicology*, 8(2), 55–64. <https://doi.org/10.1515/intox-2015-0009>

⁴² Collin, M. S., Venkatraman, S. K., Vijayakumar, N., Kanimozhi, V., Arbaaz, S. M., Stacey, R. G. S., Anusha, J., Choudhary, R., Lvov, V., Tovar, G. I., Senatov, F., Koppala, S., & Swamiappan, S. (2022). Bioaccumulation of lead (Pb) and its effects on human: A review. *Journal of Hazardous Materials Advances*, 7(100094), 100094. <https://doi.org/10.1016/j.hazadv.2022.100094>

⁴³ World Health Organization. (2024). *Lead Poisoning and Health*. Who.int; World Health Organization: WHO. <https://www.who.int/news-room/fact-sheets/detail/lead-poisoning-and-health>

⁴⁴ Ministry of Health. (2024). *Lead Program Annual Report 2024: Broken Hill children less than 5 years old* (p. 5). NSW Government.

⁴⁵ Santana, A. B., Spelta, L. E. W., Sobalvarro, J. V. M., Podestá, M. H. M. C., Garcia, R. C. T., Dos Reis, T. M., & Torres, L. H. (2023). Gestational lead exposure and its effects on fetal/infant development - A systematic review. *Reproductive Toxicology (Elmsford, N.Y.)*, 117, 108342. <https://doi.org/10.1016/j.reprotox.2023.108342>

⁴⁶ Farmer, J. G., Specht, A., Punshon, T., Jackson, B. P., Bidlack, F. B., Bakalar, C. A., Mukherjee, R., Davis, M., Steadman, D. W., & Weisskopf, M. G. (2024). Lead exposure across the life course and age at death. *The Science of the Total Environment*, 927, 171975. <https://doi.org/10.1016/j.scitotenv.2024.171975>

childhood⁴⁷. These children will need dialysis, and they will stay on dialysis because of the racist choices that get made within every public structure and system. This issue has impacted generations of Aboriginal children in Broken Hill and will continue to impact generations more until there is an acknowledgement that this is an issue of racism within a racist context.

The leading organisation for Aboriginal health in the area, Maari Ma Health Aboriginal Corporation has contributed enormously to understanding the lead issue in Broken Hill and has twice written to the NSW Government to request action that recognises the inequality faced by the Aboriginal community in Broken Hill, writing: *'This is a public health crisis wrapped in environmental injustice.'*

They have made three specific recommendations:

1. A targeted Aboriginal lead strategy.
2. Investment in Aboriginal social housing.
3. Overhaul and evaluation of the current remediation program.

These recommendations have been supported by the National Aboriginal Community Controlled Organisation (NACCHO) and by the NSW Coalition of Aboriginal Peak Organisations (NSW CAPO) but the response from the NSW Government has been lack lustre. Despite overwhelming evidence and urgent calls for action from the community, there is an unwillingness or inability by the NSW Government to recognise the lead issue in Broken Hill as a racialized problem. Responses have been centred on a business-as-usual, whole-of-government approach and a continuation of existing efforts that has so far utterly failed Aboriginal children and their families.

In a 2026 study, researchers found that partnership with Maari Ma in the Broken Hill lead screening program has been integral to increasing the screening of Aboriginal children, and *'this is a testament to the role that ACCHOs play in engaging with and delivering culturally appropriate, accessible health care to their community'*⁴⁸. This success has been achieved through a willingness to engage with the racialised nature of lead exposure and should be learned from. Racism exists in the willingness to accept a racist reality. High BLLs in Aboriginal children is an issue that will continue in Broken Hill and across Australia until that racism is recognised and addressed, and communities are empowered to change their environments. Any delay in action will result in the continued poisoning of Aboriginal children and the perpetuation of irreparable injury.

Racism can't be 'combated' in isolation from structural injustice. Cultural safety can only be determined by Aboriginal people

In order to address racism, there must be some acknowledgement that the current state is racist. These inherited institutions, healthcare, justice, government, are not equipped to create equity, and they must be changed through collaboration, partnership, and Aboriginal community leadership. In 2017, the National Constitutional Convention produced the Uluru Statement of the Heart, which stated:

Makarrata is the culmination of our agenda: the coming together after a struggle. It captures our aspirations for a fair and truthful relationship with the people of Australia and a better future for our children based on justice and self-determination.

Aboriginal self-determination and recognition of Aboriginal sovereignty is not a side effect of successful anti-racism, but a necessity for achieving it. There has been a myriad of attempts to understand and aid in the *'plight'* of Aboriginal people, the most poisonous of which have done

⁴⁷ National Kidney Foundation. (2024, August 13). *Lead Exposure and Kidney Function*. National Kidney Foundation. <https://www.kidney.org/kidney-topics/lead-exposure-and-kidney-function>

the opposite. Most notably, protectionism⁴⁸, assimilation⁴⁹, and the efforts of missionaries⁵⁰. Since invasion, Aboriginal people have been regarded as needing colonial intervention: to govern their land, raise their children, to civilise⁵¹. It is important to recognise this legacy of colonial intervention and consider the place of the colony in contemporary racism. To ‘combat’ racism is to understand racism as a downstream problem and fails to recognise racism as the conditions of the upstream⁵². Racism is the ideological alibi for who’s knowledge is privileged, who’s children can be acceptably kidnapped and poisoned, who’s experiences should be valued, and who’s land can be occupied.

To properly ‘combat’ racism targeted at Aboriginal people, we must locate racism within governing structures and establish participatory anti-racism frameworks within every facet of society and government. Racism is not only a series of conscious decisions made by individuals, but an interwoven network of mechanisms, incentives, accommodations and systems that create avoidable but inevitably racist outcomes⁵³. Therefore, it isn’t enough to be non-racist on the individual level, one must be *anti-racist* and work to deconstruct and decolonise the structures that support racism⁵⁴. Without a structural lens, racism can be excused as an individual, “bad apples” problem, which does nothing to prevent the next incident perpetrated by the next bad apple. Anti-racism works not because it punishes the racist but because it acknowledges the role of the structural incentives and accommodations that support racist behaviour and attempts to remove them.

In 2022, the Australian federal government committed to \$7.5 million over four years to the Australian Human Rights Commission to develop a national strategy to tackle racism and promote racial equality in Australia⁵⁵. The National Anti-Racism Framework was published in 2024, and contained 63 clear recommendations, informed by extensive community and sector consultations, including work with Aboriginal people and peak organisations⁵⁶. Since the framework’s publication in 2024, it has yet to be implemented in any capacity⁵⁷.

⁴⁸ National Museum of Australia. (2022). *Aborigines Protection Act*. *Aborigines Protection Act*, 1(1). <https://www.nma.gov.au/defining-moments/resources/aborigines-protection-act>

⁴⁹ Australian Human Rights Commission. (1997). *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (p. 26). Commonwealth Government of Australia .

⁵⁰ AIATSIS. (2021). *Missions, Stations and Reserves*. aiatsis.gov.au; AIATSIS. <https://aiatsis.gov.au/explore/missions-stations-and-reserves>

⁵¹ Silverstein, B., & McLisky, C. (2018). *Conflict, adaptation, transformation: Richard Broome and the practice of Aboriginal history* (pp. 38–43). Aboriginal Studies Press.

⁵² Friedman, S. R., Williams, L. D., Jordan, A. E., Walters, S., Perlman, D. C., Mateu-Gelabert, P., Nikolopoulos, G. K., Khan, M. R., Peprah, E., & Ezell, J. (2022). Toward a Theory of the Underpinnings and Vulnerabilities of Structural Racism: Looking Upstream from Disease Inequities among People Who Use Drugs. *International Journal of Environmental Research and Public Health*, 19(12), 7453. <https://doi.org/10.3390/ijerph19127453>

⁵³ Friedman, S. R., Williams, L. D., Jordan, A. E., Walters, S., Perlman, D. C., Mateu-Gelabert, P., Nikolopoulos, G. K., Khan, M. R., Peprah, E., & Ezell, J. (2022). Toward a Theory of the Underpinnings and Vulnerabilities of Structural Racism: Looking Upstream from Disease Inequities among People Who Use Drugs. *International Journal of Environmental Research and Public Health*, 19(12), 7453. <https://doi.org/10.3390/ijerph19127453>

Ngampromwongse, K., Gall, A., Garvey, G., Howard, K., & Anderson, K. (2026). It affects everything: A national study exploring racism and wellbeing for Aboriginal and Torres Strait Islander Peoples. *First Nations Health and Wellbeing - the Lowitja Journal*, 4, 100124. <https://doi.org/10.1016/j.fnhli.2026.100124>

⁵⁴ Dei, G. (1996). *Anti-racism education : theory and practice* (p. 13). Fernwood Pub.

⁵⁵ Corowa , M. (2024, October 2). Trolling of Tony Armstrong shows exactly why action is needed to stamp out racism at the ABC and beyond - ABC News. *ABC News*. <https://www.abc.net.au/news/2024-10-03/abc-independent-racism-review/104416776>

⁵⁶ Australian Human Rights Commission, The National Anti-Racism Framework: A roadmap to eliminating racism in Australia (Report, November 2024)

⁵⁷ Kurzyp, R. (2026, May 15). *Call for National Anti-Racism Framework Implementation Across Government - Australian Indigenous Doctors’ Association*. Australian Indigenous Doctors’ Association. <https://aida.org.au/media-release/call-for-national-anti-racism-framework-implementation-across-government/>

Cultural safety is a significant standard of anti-racism action and directly empowers Aboriginal perspectives. It can't be achieved simply by working through a checklist of requirements, window dressing, but is established through Aboriginal people's experiences and perspectives⁵⁸. Achieving cultural safety requires a conscious engagement with Aboriginal people, with their knowledges, experiences, and priorities to understand how individual spaces, people and systems exist within the greater context of colonisation and racism.

*Cultural safety is not experienced in the presence of racism. Addressing cultural safety is not a way of avoiding engagement with racism. Addressing, preventing and eliminating racism is at the heart of cultural safety work, coupled with ensuring Indigenous ways of knowing, being and doing are recognised, valued and enacted*⁵⁹.

In their Gari Yala report, the Centre for Indigenous People and Work (CIPW) found that 38 per cent of Aboriginal people experienced racism at work⁶⁰. But they also found that workplaces that engage in cultural safety and develop anti-racist policies and procedures not only encounter fewer instances of racism but are also considered safer environments more generally.

This is all the truer in healthcare, for both Aboriginal workers and Aboriginal consumers. Cultural safety theory evolved from Maori nursing practice⁶¹, and in particular, Dr Irihapeti Ramsden's work developing nursing pedagogy in Aotearoa⁶². This was largely in response to the inadequacy of the 'colour blind' approach that was standard at the time⁶³. This approach helped to obscure the role of racism in producing health disparities and further marginalised Indigenous consumers, as well as staff⁶⁴. Aboriginal staff in mainstream health services are often forced into an ongoing negotiation between their identity and their safety; having to reconcile with both with a presumption of whiteness as professionalism⁶⁵, and the impact of colonial load⁶⁶. In opposition to the colourblind and equality-focused approaches, cultural safety instead prioritises responsiveness, reciprocity, and relationality with the aim of achieving equity.

Cultural safety in healthcare is vitally important but requires an ongoing commitment to Aboriginal self-determination and systemic humility. There have been many attempts to systematise the implementation of cultural safety strategies, all measured using frameworks and checklists, but *'all such approaches only capture proxy measures of cultural safety rather than direct*

⁵⁸ Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, 18(174), 1–17. <https://doi.org/10.1186/s12939-019-1082-3>

⁵⁹ Mohamed, J., Stacey, K., Chamberlain, C., & Priest, N. (2024). *Cultural Safety in Australia* (p. 14). Lowitja Institute.

⁶⁰ Centre for Indigenous People and Work. (2025). *Gari Yala (Speak the Truth)*. Uts.edu.au.

<https://www.uts.edu.au/about/faculties/business/research/centre-for-indigenous-people-and-work-cipw/gari-yala-speak-the-truth>

Mohamed, J., Stacey, K., Chamberlain, C., & Priest, N. (2024). *Cultural Safety in Australia* (p. 14). Lowitja Institute.

⁶¹ Australian Institute of Health and Welfare. (2023b). *Cultural Safety in Health care: Monitoring Framework*. Australian Institute of Health and Welfare. <https://www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework/contents/background-material>

⁶² Jones, S., Hunter, K., Roberts, J., & Foster, M. (2021). Dr Irihapeti Ramsden's powerful argument for cultural safety. *Nursing Praxis Aotearoa New Zealand*, 37(1), 7–7. <https://doi.org/10.36951/27034542.2021.007>

⁶³ Ramsden, I. (2002). *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu* (p. 79) [PHD Thesis].

⁶⁴ Okah, E., Thomas, J., Westby, A., & Cunningham, B. (2021). Colorblind Racial Ideology and Physician Use of Race in Medical Decision-Making. *Journal of Racial and Ethnic Health Disparities*, 9(5). <https://doi.org/10.1007/s40615-021-01141-1>

⁶⁵ Melino, K., Bell, B., & Kaija Freborg. (2024). Deconstructing Professionalism as Code for White (Power): Authenticity as Resistance in Nursing. *Nursing Philosophy*, 26(1). <https://doi.org/10.1111/nup.70002>

⁶⁶ Gall, A., Stephens, M., Gall, Z., Armour, D., Hewlett, N., Kennedy, M., Sainty, T., Hulme, A., Wardle, J., Campbell, M., Gall, A. T., Furlong, A., & Anderson, K. (2025). First Peoples' cultural medicines: A review of Australian health policies using an Indigenous critical discourse analysis approach. *First Nations Health and Wellbeing - the Lowitja Journal*, 3(100046). <https://doi.org/10.1016/j.fnhli.2025.100046>

*assessment of patient or community experience of care*⁶⁷. The establishment of cultural safety requires the participation and response of Aboriginal consumers and cannot be meaningfully implemented without shared partnership and governance.

A commitment to formal partnerships and shared decision making was embedded within the National Agreement on Closing the Gap, explicitly describing an outcome where Aboriginal people are '*empowered to share decision-making authority with governments to accelerate policy and place-based progress on Closing the Gap through formal partnership arrangements*⁶⁸.' While support for the reform process remains strong, there are issues with the implementation of shared decision making and partnership models across all layers of government.

AH&MRC has received feedback from member services that while there have been some high-level improvements to partnership with mainstream agencies, broader executive engagement remains 'tick-boxy' despite CTG frameworks. There is a pervasive lack of understanding within mainstream health agencies regarding the ACCHO model of care, the value of the community-controlled sector, and the clinical and cultural governance capacity of ACCHOs. These partnerships require not only technical agreement but a broader understanding of why they are necessary to begin with. In a 2009 literature review of partnership agreements between ACCHOs and mainstream health agencies, researchers found that only when partnerships are genuinely grounded in the Aboriginal community do they begin affect change and that '*failure to invest in this relational process and push forward with 'business as usual' can ultimately have negative ramifications on client outcomes*⁶⁹.'

Even after a decade and a half since that literature review, unconscious bias and unaddressed racism continues to undermine shared care and partnership models, and ACCHOs still struggle to be acknowledged as experts. In order for these relationships to begin having an impact on the systemic racism embedded within the health sector, relationships with ACCHOs must not only be recognised as an important cultural safety standard, but a significant contributor to a higher standard of care. Aboriginal governance and shared care should not be considered additional to existing best practice, but foundational to providing basic service to the Aboriginal community; without it, the entirety of service delivery and management is fundamentally below standard.

Participating in anti-racism and achieving cultural safety will require an acknowledgement and acceptance that the colony is still a colony, that invasion is ongoing, and that Aboriginal sovereignty, while unrecognised, has never been ceded. Racism is not an unfortunate coincidence of cohabitation, but an avoidable failure of governance; it must be addressed at the point of accommodation and accountability must be embedded in every layer of every sector. If the problem is structural, so must be the solution.

In 1967 we were counted, in 2017 we seek to be heard. We leave base camp and start our trek across this vast country. We invite you to walk with us in a movement of the Australian people for a better future.

In 2026, there is still much work to be done, and you are still invited to walk with us in a movement of the Australian people for a better future.

⁶⁷ Elvidge, E., Taylor, S. L., Harvey, K., Thompson, Y., Armao, J., Rogers, G. B., Creighton, A., & Paradies, Y. (2025a). Empirical assessment of cultural safety within Australian hospitals highlights the impact of access to Aboriginal hospital liaison officers on the experiences of Aboriginal patients. *First Nations Health and Wellbeing - the Lowitja Journal*, 3(3), 100061. <https://doi.org/10.1016/j.fnhli.2025.100061>

⁶⁸ Australian Government. (2021). *Priority Reforms | Closing the Gap*. www.closingthegap.gov.au. <https://www.closingthegap.gov.au/national-agreement/priority-reforms>

⁶⁹ Taylor, K. P., & Thompson, S. C. (2011). Closing the (service) gap: exploring partnerships between Aboriginal and mainstream health services. *Australian Health Review*, 35(3), 297–308. <https://doi.org/10.1071/ah10936>

Recommendations

The AH&MRC proposes two recommendations

- 1 Establishment of the Makarrata Commission called for by the Uluru Statement from the Heart - *to supervise a process of agreement-making between governments and First Nations and truth-telling about our history.*
- 2 Commit funding to the full implementation of the AHRC National Anti-Racism Framework.
- 3 Commit to the development of a national cultural safety standard for the public health sector, grounded in a commitment to place-based, Aboriginal community-led, and truth-telling.



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